BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: KATHY E. Claimant, vs. VALLEY MOUNTAIN REGIONAL CENTER, Service Agency.	OAH No. N 2006060792

DECISION

Administrative Law Judge Deidre L. Johnson, State of California, Office of Administrative Hearings, heard this matter in San Andreas, California on September 13, 2006.

Kathy E. (claimant) was present and represented herself. Her grandparents were also present.

Gary L. Westcott, Ph.D., Clinical Psychologist (Dr. Westcott), represented the service agency, Valley Mountain Regional Center (VMRC).

The matter was submitted on September 13, 2006.

JURISDICTION AND PROCEDURE

On May 4, 2006, VMRC issued a Notice of Proposed Action (NOA) to claimant in which it proposed to deny services to her, effective May 1, 2006, on the grounds that claimant had been found ineligible for regional center services pursuant to Welfare and Institutions Code section 4512, and California Code of Regulations, title 17, section 54000.[1]

[1] The Lanterman Developmental Disabilities Services Act authorizes specified services for individuals defined as "developmentally disabled."

Claimant appealed VMRC's action and filed a Fair Hearing request with VMRC on June 5, 2006.

All prehearing jurisdictional requirements have been met and jurisdiction exists for this proceeding.

VMRC moved to introduce 15 exhibits into evidence. Prior to hearing, VMRC sent claimant a list of the documents it intended to use, but failed to send her copies of the documents as required by Welfare and Institutions Code section 4712, subdivision (d). At hearing, claimant was afforded time to review the documents. Claimant reads slowly and did not read all of the documents. Claimant stated that she did not want more time to finish reading. Claimant recalled which documents she had seen before, demonstrated that she understood the import of the exhibits, and objected to references to her father in one exhibit. Her objection was sustained and those references were not considered in rendering this decision. At the hearing, exhibits 3, 7, 8, and 10 were admitted into evidence. Exhibit 1 (California Code of Regulations, title 17, sections 54000, 54001, 54002, and 54010) and Exhibit 2 (Welfare and Institutions Code section 4512 - "Definitions") were not admitted, but official notice was taken of all applicable laws and regulations. The matter was submitted on September 13, 2006, subject to rulings on admission of the remaining VMRC exhibits. VMRC's remaining exhibits are admitted into evidence in the interests of justice.[2]

ISSUES

1. Within the meaning of Welfare and Institutions Code section 4512, subdivision (a),[3] is claimant developmentally disabled due to autism, which would permit her to begin to receive regional center services? If so, is the condition substantially disabling for claimant?

2. Within the meaning of section 4512, subdivision (a), is claimant developmentally disabled due to mental retardation, a condition close to mental retardation, or a condition which requires treatment similar to that required for individuals with mental retardation, which would permit her to begin to receive regional center services? If so, is the condition substantially disabling for claimant?

3. As required by section 4512, subdivision (a), does claimant have a qualifying disabling condition that originated before the age of 18?

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[2] Welfare and Institutions Code section 4712, subdivision (d) provides that a hearing officer may prohibit the introduction into evidence of documents that have not been disclosed, or may allow the evidence in the interests of justice. Subdivision (i) provides that any relevant evidence shall be admitted, and that no party shall be required to formally authenticate any document.

[3] All statutory references are to the California Welfare and Institutions Code, unless specified otherwise.

FACTUAL FINDINGS

1. Claimant was born in 1985, is now 20 years old, and is the mother of two children born in January 2005 and December 2005. Claimant has never been diagnosed with cerebral palsy, epilepsy, or autism. She does not claim to be eligible for regional center services due to mental retardation, cerebral palsy, or epilepsy. Claimant received special education and related services during her school years.[4] She was apparently in a learning handicapped special day class with resource services. Although there is no direct information about what her eligibility for special education was, VMRC staff believe it was Learning Handicapped or Learning Disability. Claimant graduated from high school and received a diploma in 2004.

2. Dr. Westcott, claimant, and claimant's grandfather testified at the hearing. Claimant had no other witnesses and no documents. VMRC had no other witnesses. Claimant has not previously been found eligible to receive regional center services. Claimant believes she may be eligible for services from VMRC due to a disability on the autistic spectrum, and several people have recently suggested this to her. VMRC contends that claimant does not suffer from either autism or the eligible categories relating to mental retardation, and that her problems involve psychological and emotional matters for which they are not authorized to provide services.

3. Claimant now resides with her grandparents in Tuolomne County. Claimant separated from the father of her children after the second child was born. She and the children then lived with his parents for a while. Claimant's children were taken into protective custody by court order in February 2006, after allegations that claimant was unable to provide the children with adequate care.

4. On February 28, 2006, VMRC, San Andreas, Intake Coordinator Catherine Moore conducted an initial assessment of claimant that was completed on March 20, 2006. Claimant was referred by David Godzina, a social worker with Calaveras Works and Human Services Agency. Ms. Moore summarized claimant's history and multiple problems in functioning, and noted that claimant was able to respond to her questions and ask very relevant questions about VMRC, the legal process and her children. Ms. Moore obtained information from claimant, the paternal grandparents, and Adult Protective Services. Her Intake Assessment report dated February 28, 2006, described claimant as having "some degree of cognitive deficits." Ms. Moore made no mention of observation of any characteristics associated with autism.

[4] Children are entitled to special education services under the eligibility criteria of the Individuals with Disabilities Education Act (IDEA), Title 20 U.S.C. sections 1400 et seq. and related California laws.

5. Claimant was referred by VMRC to Arnold E. Herrera, Ph.D., a clinical and forensic psychologist, for a psychological evaluation to assess her current level of intellectual and adaptive functioning, and to assist in determining if she is eligible for regional center services. Dr. Herrera reviewed relevant background information that reflected a complicated family history. Claimant was a victim of sexual abuse as a child and was exploited by her family for cash. In 2005 and 2006, concerns arose regarding claimant's neglect of her children, including keeping the first child in an infant seat for excessive amounts of time. There were reported incidents of claimant setting the house on fire several times, and accidents with the new baby being placed in bath water that was too hot in one instance, and endangered by inattention to his vomiting in another. The paternal grandparents reported that claimant had poor hygiene and body odor, failed to brush her teeth or groom herself, and stayed alone in her room watching television for long periods.

6. Dr. Herrera interviewed the claimant on February 28 and March 2, 2006, and administered tests, including the Wechsler Adult Intelligence Scale - Third Edition (WAIS-III); the Wide Range Achievement Test - Revision Three (WRAT-3), and the Vineland Adaptive Behavior Scales (Vineland). Dr. Herrera noted that claimant was cooperative with the testing procedure. On the WAIS-III, a verbal and nonverbal measure of general ability, claimant received a verbal Intelligence Quotient (IQ) score of 90, a performance IQ score of 97, and a full scale IQ score of 91.

7. On the WRAT-3 test of academic achievement, claimant scored a 74 in Reading, at a fourth grade level, and a 78 in Arithmetic, at a fifth grade level. The discrepancies between claimant's cognitive abilities as shown on the WAIS-III IQ score of 91 above, and her academic scores of 74 and 78 as shown on the WRAT-3, are indicative of a learning disability. Dr. Herrera also noted that his analysis of verbal subtest scatter (i.e., spread between scores) was consistent with what one sees in learning disorders.

8. The Vineland test measures personal and social skills needed for daily living, and is used to identify adaptive functioning levels when evaluating relative levels of impairments. Claimant scored as follows: Communication - 86, Socialization - 79, Daily Living Skills - 84, and Adaptive Behavior Composite score - 77. These adaptive abilities are above the delayed range, "although Socialization score was depressed to the high borderline."

9. In his written report, dated March 8, 2006, Dr. Herrera stated that claimant's performance and full scale IQ score of 91 on the WAIS-III placed her in the "low average, trending toward average intelligence." Dr. Herrera diagnosed claimant with a Learning Disorder Not Otherwise Specified (NOS), with three additional areas of Neglect of Child (claimant as victim), Neglect of Child (claimant's children), and Sexual Abuse of Child (claimant as victim). Dr. Herrera thinks claimant would benefit from training in child care and parenting, as well as counseling and treatment for depression. Dr. Herrera ruled out mental retardation. No mention was made of autism, autism spectrum disorder, pervasive developmental disorder, or pervasive developmental disorder NOS. Dr. Herrera concluded that claimant's cognitive capacity did not show developmental delay, but did reflect the

context of "a likely history of depression and low self-esteem secondary to her having been neglected and abused."

10. Dr. Westcott, a clinical psychologist and the manager of psychologists with VMRC, testified that he relied on and concurs with Dr. Herrera's opinions and diagnoses. Dr. Westcott did not personally evaluate claimant. Dr. Westcott obtained a Ph.D. from the University of Washington. Dr. Westcott became licensed in California in 1986, and has been in California regional center services since then. Dr. Westcott's dissertation involved intelligence test design, and he has conducted over 1,000 Wechsler Adult Intelligence tests. Dr. Westcott testified that claimant's IQ scores in the low average range on the WAIS-III test eliminates mental retardation as a suspected area of eligibility. Dr. Westcott testified that claimant did not have a condition similar to mental retardation, or which required treatment similar to mental retardation. It is his opinion that the types of services and treatment that claimant needs to address her learning disability, her depression, and related abuse and neglect problems, are different than the types of services that address mental retardation. Whereas a mentally retarded person may need training by breaking down a given task into simple components, claimant may need psychological counseling to recover from historical incidents, in order to access her intelligence to increase her daily functioning.

11. On March 29, 2006, an Interdisciplinary Eligibility Review meeting took place to consider claimant's request for services. The core team consisted of Ms. Moore, Dr. Stan Morrison, and John Chellsen, Ph.D. The team concluded that claimant was not eligible for regional center services.

12. On April 19, 2006, Shawn A. Johnston, Ph.D., a licensed psychologist in Sacramento, examined claimant at the request of Mr. Godzina, the social worker. A specific concern in conducting this psychological evaluation was to assess claimant's ability to provide proper parenting for her children, and to recommend appropriate services or therapeutic interventions. In addition to a clinical interview, Dr. Johnston reviewed background documents,[5] and administered psychological tests to claimant. The tests included one part of the WRAT-3, the Reading portion; the Bender Gestalt Test; the Rey-15 Test; the Draw-a-Person Test, and the Adolescent Psychopathology Scale (APS).[6] Due to claimant's limited reading ability, he did not administer the Minnesota Multiphasic Personality Inventory-2, and determined that the APS was an appropriate substitute because it was written at a lower reading level. Dr. Johnston found it necessary to read the APS test to claimant out loud to make sure she understood the questions. Dr. Johnston found claimant's intellectual functioning to be in the "below average range," although he did not provide a score, and did not administer a test designed to measure cognitive intelligence.

[5] Dr. Johnston's report dated May 2, 2006, does not describe in detail what documents he reviewed or whether one of them was Dr. Herrera's report of March 2006.

[6] It is not clear whether the APS-Long Form or the APS-Short Form was administered because Dr. Johnston's report mentions each.

13. Claimant was unable to successfully reproduce all figures on the Bender Gestalt Test, and the results indicated learning disabilities, possible right hemispheric organic impairment, and emotional constriction limiting her problem solving capabilities. Claimant's self-concept was intact in the Draw-a-Person test. Her drawings were childlike, reflecting immaturity and lack of ego strength. No evidence of malingering was detected on the Rey-15 test, and she had good immediate recall. Although Dr. Johnston did not report a score, he found that claimant read at the third grade level (1st percentile) on the WRAT-3, a grade level below that found by Dr. Herrera. The WRAT-3 also showed that claimant's long-term memory ability was extremely poor. APS is used to evaluate the presence and severity of symptoms of psychological disorders. The APS results were inconclusive due to claimant's inconsistent approach to the test. Because of this, Dr. Johnston stated that "no particular diagnosis can be definitely ruled out."

14. During the clinical interview, Dr. Johnston asked claimant a variety of questions to solicit information about her thinking, problem-solving, and parenting abilities. He found claimant to be very likeable and sweet, but seriously impaired. Claimant explained to Dr. Johnston that she did not marry the father of her children because he used drugs and yelled at her. Claimant described her childhood as "pretty happy," and denied any history of physical or sexual abuse. Claimant understood she was in special education in her school years because she was a slow learner. In the interview, claimant minimized the events that led to the removal of her children from her custody, and stated she planned to take a parenting class. Dr. Johnston found claimant's abilities to provide appropriate parenting for her two infant children, to effectively care for herself, and to function socially to be impaired.

15. Dr. Johnston concluded "with relative certainty" that claimant is functioning intellectually in the borderline mentally retarded range, and has multiple forms of psychological and social impairment. Dr. Johnston took into consideration the possibility of psychoneurological deficits suggested by the Bender Gestalt Test and claimant's history, in coming to the conclusion that his "most likely diagnosis" is pervasive developmental disorder (PDD). Dr. Johnston emphasized in his report that the "presence of borderline or outright mental retardation is an important component of a pervasive developmental disorder," and that, in his opinion, claimant's intellectual functioning is "at best in the borderline retarded range."

16. PDD is not a diagnosis per se, but is a broad class of disorders or conditions that includes autism and PDD-NOS, among others. Dr. Johnston's opinion is ambiguous because it is not known if he meant PDD or PDD NOS. Official notice is taken of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), sections 299.00- 299.80. The DSM-IV describes the class of PDD disorders as follows:

> Pervasive Developmental Disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's

developmental level or mental age. This section contains Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

The DSM-IV does not have an indexed reference to "Autistic Spectrum Disorder." Autistic Spectrum Disorder appears to be a general reference to the PDD class of disorders.

17. DSM-IV, section 299.00, defines Autistic Disorder to involve the following diagnostic criteria, and indicates that, in many cases, mental retardation is an associated diagnosis:

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(b) failure to develop peer relationships appropriate to developmental level

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

(d) lack of social or emotional reciprocity

(2) qualitative impairments in communication as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

(b) in individuals with adequate speech marked impairment in the ability to initiate or sustain a conversation with others

(c) stereotyped and repetitive use of language or idiosyncratic language

(d) lack of varied, spontaneous make-believe play or social initiative play appropriate to developmental level

(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)

(d) persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

18. As to PDD NOS, the DSM-IV, section 299.80, states that this category should be used when the problems of social interaction, communication skills, and stereotyped behaviors or interests exist, but when the specific criteria for the other disorders within the PDD category are not met. For example, the disorder PDD NOS includes "atypical autism."

19. The DSM-IV, section 317, defines mild mental retardation as an IQ level of 50-55 to approximately 70. The diagnostic criteria for mental retardation are the following:

A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning)

B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

C. The onset is before age 18 years.

20. The DSM-IV, sections 315.00 - 315.9, describes the diagnostic features of learning disorders as follows:

> Learning Disorders are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills. A variety of statistical approaches can be used to establish that a discrepancy is significant. *Substantially below* is usually defined as a discrepancy of more than two standard deviations between achievement and IQ. A smaller discrepancy between achievement and IQ (i.e., between 1 and 2 standard deviations) is sometimes used, especially in cases where an individual's performance on an IQ test may have been compromised by an associated disorder in cognitive processing, a comorbid mental disorder or general medical condition, or the individual's ethnic or cultural background. If a sensory deficit is present, the learning difficulties must be in excess of those usually associated with the deficit. Learning Disorders may persist into adulthood.

21. On May 10, 2006, claimant was referred to Galyn Savage, Ph.D., a clinical psychologist, for a second psychological evaluation regarding her ability to parent. Dr. Savage met with claimant for about three hours. Dr. Savage conducted a Mental Status Examination, and administered the Shipley Institute of Living Scale (SILS), the WRAT-3, the Millon Clinical Multiaxial Inventory-III (MCMI-III, a personality test), and the Parent Stress Index. Dr. Savage did not review Dr. Herrera's March 2006 report. Dr. Savage issued a report dated May 13, 2006 with his findings. Dr. Savage concluded that claimant was unable to effectively care for her children, and suggested supervised visits so she could learn basic parenting skills. He found claimant to be passive, compliant, with limited vocabulary, and cognitively impaired.

22. On the SILS test, a neurological screening instrument which provides an estimated IQ, claimant's scores were so low that they were not considered valid for the test. Claimant obtained a Below Average score on the Abstract Reasoning portion, and a low first percentile score on the Vocabulary portion. Dr. Savage concluded: "The discrepancy between her scores suggest [sic] a Verbal Learning disorder. Further neurological and cognitive testing would be required to confirm this hypothesis." On the MCMI-III, claimant's results were also invalid. During the assessment, claimant tried too hard to present herself in a desirable manner instead of providing accurate responses.[7] Claimant obtained a third grade score on the Reading and Spelling portion of the WRAT-3, in the functionally illiterate range. Dr. Savage opined that claimant has forgotten much of the basic

[7] Dr. Johnston's report contains a similar observation and concern regarding claimant's efforts, that may have affected his test results as well.

academic knowledge that she once had to obtain a high school diploma. The Parent Stress Inventory results were also invalid as claimant's defensive responses could not provide an accurate description of her functioning.

23. Dr. Savage indicated that he concurred with Dr. Johnston's diagnosis of "PDD," because claimant presents as a person much younger than her actual age, and lacks the cognitive or neurological capabilities to "glean meaningful lessons from her experiences." The diagnosis is poorly supported. The reasons Dr. Savage noted do not correlate to the diagnostic criteria for PDD NOS.

24. On August 4, 2006, Dr. Savage wrote a letter to VMRC, in which he indicated that he evaluated claimant a second time at the request of Calaveras Works and Human Services Agency "to aid in her application for services from either VMRC or SSI, as she is unable to support herself." This time, Dr. Savage reviewed Dr. Herrera's report, which he had not reviewed in connection with his May 2006 assessment of claimant. Dr. Savage was "stunned" to see how well claimant did on the WAIS-III IQ test. Dr. Savage stated that, while claimant's IQ scores are higher than the standards VMRC follows, he still concludes that her level of daily functioning is "in the mentally deficient range." He described claimant's functional deficits to include not being able to look up telephone numbers in the phone book, not knowing how to cook, not having any friends, having impaired judgment, and in need of extensive out-reach services. Dr. Savage concluded that claimant appears to suffer from some atypical form of autism. Dr. Savage based this opinion on both the large discrepancy between her IQ test scores and her difficulty with basic daily skills, and her serious impairments in social, academic, and occupational functioning.

25. Dr. Westcott disagreed with the opinion of Dr. Johnston as to a diagnosis of PDD with an associated diagnosis of borderline mental retardation. Dr. Westcott also disagreed with Dr. Savage's opinion. Dr. Westcott and VMRC have been using Dr. Herrera as one of the psychologists to provide cognitive, academic and adaptive assessments for six or seven years, and consider him an expert in autism. Dr. Westcott and VMRC have been actively involved in the development of autism programs since the late 1980's. VMRC partnered with the University of California San Francisco, Stanford University, and the Lovaas applied behavior analysis program at the University of California Los Angeles[8] to create programs to address autism at VMRC. Dr. Westcott does not consider either Dr. Johnston or Dr. Savage to have expertise in autism or PDD disorders, and thinks that their views about PDD are erroneous.[9] Neither Dr. Johnston nor Dr. Savage administered any assessment tests specific to autism. Dr. Herrera, who is an autism expert, did not conduct any autism-specific tests on claimant, and it must be assumed that he found no reason to do more specific tests for autism.

[8] Dr. O. Ivar Lovaas, "Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children" (UCLA, 1987).

[9] Even if their views of PDD were accurate, PDD NOS is not a defined condition of eligibility under the Lanterman Act.

26. Dr. Westcott testified that if autism were suspected in claimant's case, VMRC would have provided claimant with further appropriate assessments. Dr. Westcott testified that claimant displays none of the behaviors that would lead to any suspicion that she may have autism. In social referencing, claimant has alert eye contact as Dr. Westcott observed during the hearing, she responds reciprocally, and does not have repetitive abnormal behaviors. In addition, claimant's score of 91 on the WAIS-III eliminates consideration of mental retardation. The testimony of Dr. Westcott on the issue of claimant's intellectual capacity, based on Dr. Herrera's assessment, is given great weight. Dr. Johnston did not conduct an intelligence test, and Dr. Savage only administered the SILS test, with invalid results. Dr. Westcott credibly testified that, given claimant's low-average to average intelligence, the large discrepancy between that and her very low academic functioning appears to fall within the criteria for a learning disability.

27. In addition to claimant's learning disability, Dr. Westcott concurred with Dr. Herrera's diagnosis and opinion that claimant's adaptive functioning problems and depression need to be viewed in the context of her history of having been neglected and abused. Dr. Westcott concurs that claimant should receive psychological counseling.

28. Claimant testified that the health services personnel she has recently seen want her to take pills for depression, but she does not want to take pills. She currently has a job at an ice cream parlor at Columbia Park. No one ever informed claimant during her school years in special education that they suspected she had an autistic disorder, or that she was mentally retarded. Claimant's grandfather confirmed that claimant has always been "slow" but never considered mentally retarded or autistic.

29. Claimant represented herself at the fair hearing and appeared to understand most of the testimony of Dr. Westcott. Claimant agreed with Dr. Westcott's opinion that she is not mentally retarded, and is proud that she graduated from high school. Claimant did not present any evidence that she is autistic or mentally retarded, has a condition closely related to mental retardation, or that she needs treatment similar to that required for mental retardation.

LEGAL CONCLUSIONS

Applicable Statutes and Regulations

1. Welfare and Institutions Code section 4512, subdivision (a), states:

> (a) "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism.

This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

2. California Code of Regulations, title 17, section 54000, states:

(a) “Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a

> neurological impairment that results in a need for treatment similar to that required for mental retardation.

Eligibility

3. In order to qualify for regional center services, claimant must have a "developmental disability." A developmental disability for purposes of the Lanterman Act is limited to mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation, or which require treatment similar to that required for individuals with mental retardation. The condition must also have originated before the age of 18, and be substantially disabling. (Wel. & Inst. Code § 4512, subd. (a)). California Code of Regulations, title 17, section 54000, subdivisions (c)(1) and (c)(2) state that a handicapping condition that is solely a psychiatric disorder, or solely a learning disability does not meet the definition of a developmental disability.

4. It was not established by a preponderance of the evidence that claimant is mentally retarded, that she has a disabling condition that is closely related to mental retardation, or that she has a disabling condition that requires treatment similar to that required for mentally retarded individuals. As set forth in Findings 6, 7, 9, 10, 19, and 26, claimant's full scale IQ score of 91 eliminates mental retardation from consideration. The claimant does not meet the first portion of the DSM-IV definition of "significantly subaverage intellectual functioning" with a score of 70 or below. (Findings 12, 13, 21, and 22.) It is therefore not necessary to reach the second portion of the DSM-IV definition of mental retardation, the element of "deficits or impairments in present adaptive functioning."

5. Claimant's low-average IQ scores also rule out a determination that claimant has a "closely related" disabling condition. (*Mason v. Office of Administrative Hearings* (2001) 89 Cal. App. 4th 1119.) (Findings 6, 9, 10, 19, and 25.) There was no evidence to indicate that claimant requires treatment similar to that required by individuals with mental retardation, such as breaking down simple tasks with repetitive training.

6. It was not established by a preponderance of the evidence that claimant suffers from autism. Autism is the only disorder on the PDD or autistic spectrum that qualifies for services under the Lanterman Act. (Findings 4, 5, 9, 10, 15, 16, 17, 18, 22, 23, 24, 25, and 26.)

7. The evidence established that claimant received special education services during her school years, most likely based on a diagnosis of specific learning disability (Finding 1).[10] Claimant's most recent test results show a significant discrepancy between cognitive ability and academic achievement, thereby suggesting that claimant has a learning

[10] Claimant was entitled to have a transition plan as part of her special education program, including postsecondary goals related to training, employment, and independent living skills. The record is silent as to whether claimant received such services, but the issue is not within the jurisdiction of this proceeding.

disability (Findings 6, 7, 9, 10, 12, 13, 20, 21, 22, 26, and 29.). A learning disability does not constitute a developmental disability within the meaning of section 4512, subdivision (a).

8. It is clear that claimant's daily functioning is impaired at least as to self-care, self-direction, functional academic skills, and parenting. (Findings 3, 4, 5, 7, 8, 9, 10, 13, 14, 21, 22, 23, 27, and 29.) All three psychologists who assessed claimant, Dr. Herrera, Dr. Johnston, and Dr. Savage, noted that claimant has multiple psychological and social deficits. (Findings 9, 14, 21, 22, and 24.) These impairments, while limiting claimant's daily functioning, do not constitute a qualifying developmental disability for purposes of regional center services. The same conclusion would be reached if the impairments constitute a psychiatric disorder, because of the limitations of the Lanterman Act.

Conclusion

9. Claimant failed to produce sufficient evidence at hearing to establish that she is developmentally disabled as defined in the Lanterman Act. Consequently, she is not eligible for regional center services under the criteria set forth in applicable laws and regulations.

ORDER

Claimant Kathy E.'s appeal to be determined eligible for regional center services is denied. Valley Mountain Regional Center's decision to deny Claimant's eligibility is affirmed.

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.

Dated: _____

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DEIDRE L. JOHNSON
Administrative Law Judge
Office of Administrative Hearings